PRIOR AUTHORIZATION REQUEST FORM PHYSICIAN OTOLOGICAL REPORT

This form is required by Wisconsin Medicaid when a hearing instrument specialist requires prior authorization for a hearing instrument.

- · COMPLETE EACH ITEM ON FORM.
- GIVE FIRST PAGE TO THE RECIPIENT TO TAKE TO THE TESTING CENTER.
- RETAIN SECOND PAGE FOR YOUR FILES.

1 PHYSICIAN NAME, ADI	CITY, STATE, ZIP CODE)	2 EVAL	UATION DATE		3 PHYSICIAN'S SIG	NATURE A	ND DATE			
			I	MM/DD/YYYY		SIGN	ATURE		M.D.	MM/DD/YYYY
				SICIAN'S UPIN, MEDIC	AID, OR L		ATORL	5 PHYSICIA	N'S TELEPHOI	
								1	1	
6 RECIPIENT'S MEDICAID ID NUMBER				7 SEX		8 RECIPIENT ADDRES	SS (STREE	T, CITY, STA	TE, ZIP CODE)
				_	_					
9 RECIPIENT'S NAME (LA				M F	= 🔲					
3 NEON LEVY O NAME (EA	(O1, 1 11(O1, W.I.) A	O ON WEDIOAID ID OAKD		TO DATE OF BIRTH						
11 MEDICAL HISTORY O	NE HEARING LOSS	:								
TI WEDICAL HISTORY O	F HEARING LOSS									
12 PERTINENT OTOLOG	GICAL FINDINGS				13	ADDITIONAL FINDING		dies. such	as	
		NORMAL F (Check below)	PROBLEMS (Describe)	3		caloric and				
RIGHT	Canal	[]								
	Ear Drum	[]		_						
	Middle Ear	[]								
LEFT	Canal	[]								
	Ear Drum	[]								
	Middle Ear			_						
14 CLINICAL DIAGNOSIS	S OF HEARING ST.	ATUS								
15 MEDICAL, COGNITIVE	E, OR DEVELOPM	ENTAL PROBLEMS								
16 PHYSICIAN'S RECOMM	•									
[] Iha	ive medically	evaluated this pat	tient and re	efer him/her for	a hear	ing instrument e	valuatio	n as folio	ows:	
		of the situations lis							caid	
r	_	refer this patient t		_	ring in	strument evalual	แดก/ตเสดุ	gnosis:		
		patient is 21 years								
		patient is behavio	-			robonoivo ovolua	tion			
		patient has other socialized diagnos					luori			
		above situations ap y provide the hear				udiologist or a he	earing i	nstrumen	t	
f 1 ,	A home hear	ing test may be re	nuired							